WHO-SEARO Workshop
Re final guidelines
18-21st Jan 2000

Sudhal
SR-2-S2/RB-2/ (536)

GUIDELINES

WHAT?	COMMUNITY MOBILIZATION AND ADVOCACY AND SUPPORTIVE ACTIVITIES
HOW / WHERE?	1. These guidelines were evolved through an interactive, participatory workshop held in Bangalore, facilitated by the Community Health Cell, Society for Community Health Awareness, Research and Action, Bangalore (CHC) from 9-11th December 1999. (It also drew up from an interactive, participatory process report entitled "Towards an Appropriate Malaria Control Strategy" that was facilitated by the Society and VHAI, New Delhi, in 1997) 2. It was finally reviewed and revised in the context of the South Asian diversity and restructured in an informal consultation at WHO-SEARO on 18-21 Jan 2000.
WHO?	1. The participants included resource persons from academic and research centres, field NGOs, NGO support groups, and citizens groups. The group was multidisciplinary with multi level experience in health care and control of communicable disease programmes (See Appendix 1). 2. A group of consultants from WHO-SEARO and the region.
FOR WHOM?	The effort was to evolve simple, generic guidelines for Malaria Programme officers and their partners primarily at district level. Some guidelines were found necessary for the state / national / regional levels as well so that the programme at district level benefits from support at higher levels as well. (e.g., structural inputs, human and material resources inputs, and planning and management backup). These have been indicated.
WHY?	To develop advocacy, community and partner mobilization initiatives as a crucial component of RBM programme in the country.

ADVOCACY, COMMUNITY AND PARTNER MOBILIZATION

1. Introduction

Malaria continues to be one of the most serious public health problems in the SEA region. 85% of the total population in Southeast Asian countries is at risk of malaria, with 35% living in moderate to high risk areas.

Malaria has adverse effects on economic and social development. Malaria has been called the single biggest cause of poverty in some countries. Morbidity caused by malaria reduces family earning by 12% and a weakened workforce brings down productivity.

The process of development itself contributes to the spread of malaria. As roads are built, forests cut down, new mining areas opened, habitats which favour the breeding of mosquitoes, expand.

The RBM is different from previous efforts to fight the disease. While drawing on the strengths of past experience in malaria control, it focuses on political commitment, community empowerment, inter sectoral linkages and partnerships with the private sector, NGOs and other health related programmes.

The focus is on finding local solutions to local problems while drawing on potential resources outside the health sector. With this aim in mind, Roll Back Malaria project emphasises decentralisation and district level planning with the full involvement of community and other partners.
The National malaria control programme assumes a role of leadership, facilitation, co-ordination and regulation and not of sole implementation.

ADVOCACY, COMMUNITY and PARTNER MOBILIZATION

2. About the guidelines

Advocacy and Community and partner Mobilization are central to the Roll Back Malaria initiative. RBMI is draws on the PHC strategy and aims to strengthen the district health system. Mobilisation and advocacy are therefore deeply embedded in the Primary Health Care approach.

This is done through the emphasis on (i) Community participation (ii) the use of Appropriate technology (iii) Intersectoral coordination (iv) social equity – central to the strategy of the control programme.

The following principles form the *blueprint* to these Guidelines:

1. The '**Community'** in the urban slum, the rural or tribal area must first be, accepted at all levels of the control strategy as **'active participants'** of the programme and not **'passive beneficiaries'**.

2. The **community** and/or its representatives both formal and informal leaders, should be **involved in the planning** and **organisation of the activities at all stages** of the programme. A village health committee will operationalise this further.

3. The **focus** of the activities / strategies should not just be on providing the community, a package of services but actively **enabling / empowering them** to **participate in decision making** that helps them to make health their own responsibility.

4. The large number of **human resources** that are available in any community must be identified and **mobilized** to participate in the programme.

5. The Primary Health Care approach is a comprehensive approach and therefore Malaria control programmes should not become unipurpose or selective in their orientation and whether it is the village committee, the health guide, or the strategy, there should be scope and openness to use the **same structures and resources for other disease and health problems in the community /**

country.

6. A major thrust of such a primary health care oriented programme will be the approach of **demystifying the problem** at the community level, to **build confidence and perspective to tackle** it at the level itself so that the health team works in close partnership with the people and the **programme becomes identified by the people as their programme.**

7. The Primary Health Care approach also calls for a certain humility in the health team about not always wanting to 'teach' or tell the people something but also a willingness to learn from local experience, wisdom and health culture. The people, when provided the right forum and context will often share ideas, options, alternatives that the health teams should consider and new approaches or alternatives can emerge if this learning from the people and **working 'with them'** rather than 'for them' becomes a team commitment.

In practice:

These concrete guidelines are intended for use by all partners involved in RBMI. They identify the steps required at district level to broaden the range of partners in the control of malaria (supported by national, state/division level):

- With the communities
- With sectors other than health (education, ...)
- With non-government, civil society organisations
- With the private sector (medical and non-medical)

They are designed to be applicable and suitable for use in the field. They have been arranged in logical and chronological sequence of activities. Case studies and a few examples have been included to illustrate the possible applications.

"Health is created and lived by people within the setting of their everyday life, where they learn, work, play and love."

3. ADVOCACY

As the causes of malaria lie outside the control of the health sector, obtaining political will for malaria control, is an essential first step. Intersectoral collaboration is an important principle of RBM, and this will need advocacy at many levels.

- **At the National level**: Political commitment must be obtained at the highest level to ensure inter ministerial collaboration, as well as sufficient budget allocations to fight malaria. It is important that top leadership is convinced about the need for action across various sectors, and makes the necessary commitment for this. It is also important that the lop leaders make public commitment to the cause.

WHO and the Health Ministry need to make a strong case, based on evidence of the importance of such commitment and action.

Special advocacy materials need to be produced to present the case . Print and audio visuals materials would clearly spell out the issues. These would need to highlight the argument that malaria is a net drain both on the health of the people, and on the workforce, causing a negative impact on the economic productivity of a country. National data is needed so that the argument is based on evidence. Different versions would target separate key stakeholders: eg: government/ other ministries/Chief Ministers of states/captains of industry/ the news media.

Role of media: At the national level, media need information to understand the scale of the problem, in health and economic terms. The link with environment degradation and unplanned urbanisation are issues already under media scrutiny in most countries. The malaria issue's linkage to these needs to be made apparent. The news media offer a good channel to set the agenda and make malaria control an issue, particularly at the national level. They can ask questions, and play a watchdog role.

- **At the State/sub-national level:** A similar high level commitment must be sought from the top political leadership. This would translate into inter department cooperation. As different states would have varied situations, the malaria situation must be spelt out for that state. Health ministries/departments must obtain the health and the economic data related to malaria morbidity/mortaility for that state. Advocacy materials at this level would use this in the formulation of key arguments.

Role of media: At the state level too, the news media play an important role in setting the agenda, in awareness creation among the policy makers, creating public

awareness, and in following up on action taken or the lack of it.

- **At the District/Municipal levels**: Activate the district/ municipal administration /mechanism to ensure implementation and monitoring of the programme components. The private sector/other departments/service organizations, eg. Rotary etc/ the media. are to be targeted for advocacy.

Role of media: At the district level, the media can be used increasingly for information dissemination, about the problems related with malaria, possible community action, role of the service organizations and the private sector. Media has a greater role in social mobilization and support to social marketing, at this level.

The steps for advocacy at all these levels include

1. Analyse situation and problem
2. Design strategy (What are the messages to be communicated)
3. Mobilise resources
4. Implement action
5. Evaluate results
6. Plan for continuity

(further details will be included with ref to "A" Frame for advocacy" JHSP)

We need not only to persuade the people to accept the professional's wisdom, but also the professional to understand people's wisdom.

GUIDELINE ONE

PARTNERSHIP WITH THE COMMUNITY

OBJECTIVES:
The objective of Roll Back Malaria is to promote the broad participation and ownership of the community in malaria control. This will be done through the active mobilization, involvement and participation of the community in the planning, implementation and monitoring of the health programme.

This can be evolved in five steps:

Step one: Building community leadership.
Step two: Sensitising the community.
Step three: Empowering the community.
Step four : Building community capacity.
Step five: Sustaining the community partnership.

Step One: Building Community Leadership.

1. ***Identify leadership in the community (this may be village, tribal hamlet or township)***

1 (a)These would include:

- Formal leaders
- Informal opinion leaders
- Community clubs and organisations – youth, women, farmers,
- Teachers
- Religious and community leaders
- Village health workers / local development workers
- Others in the community who could assume leadership roles.

1(b) Proactively increase the participation of women members by involving women's groups.[1]

1 (c) Ensure adequate representation of marginalised/ minority groups.

2. *Evolve the health committee at community level with the involvement of the people*

- If there is a *functional* health committee or group already, integrate malaria function with that group.

- If a *functional* committee does not exist then evolve a malaria committee which can take up other programmes at a later stage.

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[1] for example, mahila mandals in India; PKK in Indonesia and MMCWA in Myanmar

3. ***A dialogue of the district administrator[2] with the community leadership/committee should be initiated to elicit the participation in the Malaria Programme.***

4. ***Orient the leadership/committee to the malaria situation and malaria control to get their help in sensitising the community***

Step Two: Sensitising the Community

Through community level meetings, sensitise the community to all aspects of malaria situation and malaria control.

1. Create awareness of national malaria programme at village/township level and define the expected role of all members of the community.
2. Make the community aware of the following:

   a) that they are partners in the programme and have their roles and responsibilities in malaria control, and
   b) that their participation will ensure benefits to their community.

Step Three: Empowering The Community.

1. Initiate a dialogue using participatory approaches to understand the existing knowledge, attitudes and practices of the community in relation to the malaria problem.
2. Assess the strengths and weaknesses from the KAP exercise against the expected behaviour.
3. Create awareness in the community on the causes, signs and symptoms of malaria and about the treatment and prevention of malaria.
4. Involve them in a planning exercise:
   - to survey and identify the local situation,
   - the identify the existing resources in the community including volunteers who could be trained for the programme,
   - to identify external resource inputs that will be required, and
   - to develop a plan of action for malaria control that could include health promotion, early diagnosis and treatment, and malaria prevention activities(including vector control).

5. Facilitate the operationalisation of this plan by :
   - helping them to implement,
   - helping them to monitor,
   - and helping them to review and revise the plan of action.

Step Four: Building The Capacity Of The Community

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[2] ***(for example, District Collector in India and Bhupathi in Indonesia)***

Helping the community to build its capacity for malaria control activities will essentially mean building the capacity of leaders and local volunteers in a variety of tasks.

1. *To understand all aspects essential for malaria control (A to Z) Malaria – A to Z*

    a) *What is the current magnitude of malaria problem : National / State / District / Local*
    b) *What is malaria – its symptoms and characteristics for identification?*
    c) *How is malaria caused?*
    d) *Where do mosquitoes come from?*
    e) *Where do they breed?*
    f) *Who are at most risk of suffering from malaria?*
    g) *How can we test for malaria?*
    h) *Where can these tests be done?*
    i) *What can be done to treat malaria?*
    j) *Where is the treatment available?*
    k) *How can we control the mosquitoes?*
    l) *What are the complications of malaria?*
    m) *What should be done in case of complications?*
    n) *What are the protective measures against mosquito bites?*

2. To build the capacity of volunteers/leaders in:

    - early diagnosis and treatment
    - identification of serious cases and their suitable referral
    - community surveillance of malaria morbidity and mortality.
    - vector control activities at community level (see Appendix __)
    - communication and mobilisation.
    - monitoring and evaluation at community level.

***Step Five*: Sustaining the community partnership.**

Community partnership can be sustained by:

1. Frequent interaction with community, providing solutions to the problems in carrying out control activities will also sustain the interest of community in malaria control activities.
2. Ensure that supplies are constantly available (insecticides, fish, nets, medicines, neem oil, equipment, microscopes, stain, slides). This will also greatly help the sustainability of the programme.
3. Encouragement of income generating vector control activities will also help sustainability of the community involvement.
4. Incentives for the community from the district administration in the form of:
    a) declaring malaria-free or healthy villages
    b) developmental inputs.

"True partnership begins when the community involved decide what needs to be done

and particularly what needs to be done first."

GUIDELINE TWO

BUILDING OTHER PARTNERSHIPS
General Principles

1. ***Partnership diversity.*** To sustain the community level malaria control activities, there is a need to build a relationship with a wide variety of partners. These could be:

- NGO sector
- Private sector
- Educational sector
- Other developmental sectors including agriculture, irrigation, construction, industry, etc.

2. ***Partnership characteristics.*** This relationship could be based on different characteristics:

* product based partnership
* product development based partnership
* services based partnership
* systems and settings based partnership
* issue based partnership
* health message based partnership
* knowledge based partnership

(examples to be included)

3. ***Partnership process.*** The process of building and managing partnerships would include:

* identifying opportunities
* selecting suitable partners
* negotiating /reaching clear partnership agreement
* maintaining partnership, and
* regularly evaluating the partnership.

These partnerships will not just come about: they will have to be built with skill, care and mutual trust.

Partnership is an alliance in which individuals, groups or organisations agree to:

- *work together to fulfill an obligation,*
- *undertake a specific task,*
- *meet a shared objective,*
- *share the risks as well as the benefits,*
- *review the relationship regularly,*
- *revise the agreements as necessary*

GUIDELINE 2 (a)

PARTNERSHIP WITH NGOs

.The role of NGOs especially the voluntary agencies (not for profit NGOs) is being increasingly recognised in planning and policy circles as an effective complementary / supplementary strategy.

2. In the past, they have played this role without much governmental support. In more recent years a greater degree of collaborative effort is emerging as a policy alternative.

3. The Voluntary agencies (Volags) have their Strengths

a) They are closer to the people and usually more aware of grass root realities.
b) They often work in more interior and inaccessible areas or in accessible areas with more marginalised groups and the underprivileged.
c) They tend to be idealistic and committed to certain values and principles.
d) They often have a stronger development orientation and awareness building commitment and skill.

4. The Voluntary agencies (Volags) have their Weaknesses as well:

a) They are very dispersed and individualistic and not woven into any integrated network.
b) They are often aloof from governmental programmes having their own programmes and agenda.
c) They are very diverse in their size, type, ideology, focus, distribution, lineages and professional competence.
d) They are inadequately informed about governmental programmes and initiatives and often lack adequate professional expertise being stronger in motivation rather than in skills.
e) They often follow fund driven / donor driven agendas.
f) They are also not often present in areas where they are needed most.

Notwithstanding these shortcomings, it is a very important development that the opportunities of government – non-governmental collaboration are being increasingly promoted in recent years though involvement in malaria care is still not significant.

1. Partnership with NGOs could be in the following areas:
   A. ***Community awareness.*** As the NGOs work with local communities, they understand the community dynamics and the local culture. Their support can be harnessed to increase community awareness using indigenous and local methods that they are often good at.
   B. *Community planning.* Many NGOs promote participatory methods of problem identification and planning, and hence can support the RBM initiative at the district level to enhance bottom up planning and incease the community ownership of the programme.
   C. *Community mobilisation.* Many NGOs are experienced in mobilising all sections of the community for their programmes, and their skills could be harnessed for the RBMI.
   D. *Socio-epidemiological research.* NGOs could be involved with studies of local knowledge, attitudes, practice and behaviour studies, social organisation patterns, etc.
   E. *Diagnosis and treatment.* Since many NGOs have a community base, they are the first level contact in the community and enhance access to diagnosis and treatment or build community's capacity for the same.
   F. *Epidemic preparedness*. Some NGOs can be involved as sentinel centres for epidemic preparedness as they are closer to the community.

2. The process of the partnership would involve some or all of the following:
   A. Identification of appropriate NGO partners
   B. Sensitisation and capacity building of these partners
   C. Sharing of information
   D. Participatory planning
   E. Monitoring and review, and
   F. Documentation.

3. Partnership with NGOs could be operationalised with individual NGOs working at community level or through NGO networks and NGO training and resource centre that have a good district and community level presence.

4. The services of many NGOs in health and development have been harnessed in the past for national health programmes in the past particularly focused on maternal and child health and family welfare. The mechanisms and human resources for these programmes could be utilised for the RBM initiative but capacity building of these NGOs specifically for malaria control would have to be carried out. This capacity building will include all the issues listed above.

Guideline 2(b)

PARTNERSHIP WITH PRIVATE SECTOR

Private sector at district level would consist of one or more of the following groups:

1. Health Care Providers:
   * general practitioners of all systems of medicine
   * dispensaries, hospitals and nursing homes
   * laboratories and diagnostic centres
   * chemists and pharmacists

2. Health Product manufacturers of:

   * pharmaceuticals
   * insecticide
   * bednets and personal protection equipment.

3. Non-health private sector including corporate sector, small scale industry, construction, engineering, etc.

Guidelines

1 Building a partnership with all the above would involve the following steps:

A. identifying all potential partners from each of the groups above at the district level.

B. sensitising them and make them aware of various aspects of malaria control

C. helping them adopt malaria control initiatives in their own work places, and

D. identifying the role and the contribution they could make to the programme.

2. Each of the above groups could contribute to the programme in various This would vary with different groups:

A. Health Care providers. They should be encouraged to:

* adopt scientific and rational diagnosis and treatment of malaria.
* provide referral support wherever feasible.
* Support IEC at patient, family and community level in their area.

For this purpose CME programmes, bulletins, newsletters and handouts may have to be prepared in collaboration with professional associations/institutions. CMEs must specifically address the following trends in malaria control in the private sector:

i. *a use of a wider diversity of irrational regimes and combinations often at high cost to the patient and totally at variance with the NMEP guidelines.*

ii. *a tendency to exploit the illness episodes by the use of injectable preparations and other adjuncts not in consonance with the principles of rational malaria care.*

iii. *a tendency to see the 'outbreak' or 'epidemic' as an opportunity for gain rather than as an opportunity to be actively involved in a national health programme and national efforts to tackle a major public health programme.*

iv. *These trends are further complicated by an increasing fall in clinical diagnostic standards and inadequate recourse to lab diagnostic facilities. The clinical laboratories also have been showing a lack of quality and standardization even when they are available and utilized.*

v. *Further some degree of medical misinformation by medical representatives pushing their company's remedy against the other to enhance profit margins even when low-cost generics are available is a growing problem.*

vi. *The obvious result of such continued, irrational medical practice is reflected in the increasing problem of drug resistance, as well as the continuation of unnecessary and avoidable suffering.*

B. Health Product manufacturers: Opportunities should be explored with all local manufacturing industries to produce malaria control related products that are low-cost and appropriate to the local needs:

- Nets
- Mosquito repellants
- IEC material

C. Non-health private sector: They could be harnessed at district level for providing the following:

* financial resources for the programme
* promotion and marketing skills.
* taking steps to prevent mosquitogenic conditions in their institution / project areas.
* Support IEC

GUIDELINE 2(C)

PARTNERSHIP WITH AGENCIES INVOLVED WITH EDUCATION OF CHILDREN AND YOUTH.

Principles

1. Target for behavioural change

- School and college going children (6-21 years)
- School drop-outs
- Children with no formal education.

2. Partners

- Local schools – primary, middle and high schools.
- Colleges
- Non-formal education .

3. What is expected from children and youth:

- know cause and control of malaria, change attitude and practice preventive measures
- involve in health education campaigns to create awareness among community
- participate in mosquito breeding preventive measures (in and around educational institution)

4. What is the role of partners?

- inclusion of health education in school / college curriculum
- motivate the students
- mobilize their participation in preventing mosquito breeding
- involve them in community awareness programmes.

Content Clarity

Some or all of the answers to the following questions must be included in the awareness / education programme depending upon the target age. The content needs to be presented in interesting, interactive forms whereby the children and youth can learn from participating in situations and role plays that make a lasting impression. The questions are:

a) What is malaria – its symptoms and characteristics for identification?
b) How is malaria caused?
c) How does it spread?
d) Where do mosquitoes come from? Where do they breed?
e) Who are at most risk of suffering from malaria?
f) How can we test for malaria?
g) Where can these tests be done?
h) What can be done to treat malaria?
i) Where is the treatment available?
j) Personal protective measures against mosquito bites
k) How can we control the mosquitoes breeding?
l) What are the complications of malaria?
m) What should be done in case of complications?

Guidelines for advocacy for partnership in school / college health education

District level

i) Involve the education department in celebrating malaria month by carrying out anti-malaria activities on the occasion.
ii) Involve science clubs and science networks in increasing awareness about anti-malaria activities amongst children and youth.
iii) Conduct seminars / guest lectures / demo-exhibitions / field trips / essay competitions / debates appropriate to the level of schooling / education.
iv) Explore the possibility of inputs by teachers and students into fairs and festivals
v) Including the practice of vector-control activities by students and youth in scout movements, national defence and social service auxillary corps
vi) Exposing students and youth to various aspects of malaria by including malaria related activities and experiments as project
vii) Initiating debates / competitions between schools, colleges, and universities on malaria control and on vector control to create widespread awareness.

To sustain the above:

- Have regular meetings with teachers and staff involved in education.
- Have capacity building/training sessions for volunteers, teachers and high school students.
- Organise events at regular intervals to maintain the interest and tempo of awareness activities in the educators and the students / youth.

Guidelines For Advocacy With Agencies Involved In Non-Formal Sector Of Education

Agencies like NGOs, Slum Welfare Boards, Social Welfare Boards and the educational department that are involved with street children, child labour and school dropouts must also be encouraged to increase awareness about various issues regarding malaria through appropraite efforts from those mentioned in the guidelines above and those given in section on partnership with voluntary agencies.

School Health Education on Malaria in Goa - I
A Case Study

With an aim to make students in schools of Goa malaria literate, a systematic education programme was devised and initiated in Goa, in 1992 by Malaria Research Centre, Goa, in collaboration with Indian Red Cross Society, Goa. This programme was implemented in phases starting 1992 when 81 schools were enrolled targeting 16211 students from 8th to 10th standard. In 1994, this programme was extended to Higher Secondary classes up to 12th standard and by 1998, 227 schools participated in the programme targeting 53,462 students throughout Goa.

The aims and objectives of the programme were us under:

1. To introduce teaching on Malaria in the entire state of Goa in school children through Junior Red Cross (JRC) and Youth Red Cross (YRC) components in Secondary and Higher Secondary classes.

2. To train JRC and YRC counsellors (Teachers) to impart malaria education to the students.

3. To prepare curriculum on malaria and seek its ratification from Goa Board of Secondary and Higher Secondary Education.

4. To reach community through these students and teachers so as to train and involve people in the vector and disease control process.

5. To undertake field projects on malaria with the help of Red Cross counsellors and volunteers (students) wherein the local community is exposed to the problem and its remedial measures.

6. To prepare a cohesive force over a period of time in the community who would practice the mosquito / vector control in their day to day life and also continue to disseminate the self action idea to others in future.

Training of Red Cross Counsellors

Thirteen State Level Workshops have so far been organised by the MRC and Red Cross for imparting Orientation training to 808 teachers with the understanding that organisational and technical responsibility will be shared by the red cross and MRC Goa Field Station respectively.

The technical aspects of training included lectures, preparing course material, hand outs, audio visual aids, and films and exhibitions on malaria. 61 exhibitions were organised for 24,133 students in 232 schools.

1. Immature and adults of Anopheles, Culex and Aedes mosquitoes explaining the life-cycle and their distinguishing features.
2. Models of domestic and peridomestic breeding habitats. These focussed upon man's negligence and indifference which may support the growth of mosquito populations.
3. The control aspects demonstrated, consisted of:
   - i. Larvivorous fish such as Aplocheilus blockii, Rasbora daniconius, Gambusia affinis and Poecilia reticulata devouring mosquito larvae and pupae.
   - ii. Bacillus thuringiensis and Bacillus sphaericus samples.
   - iii. Expanded polystyrene beads (EPS) forming a top layer on the water in the model of an unused well.
   - iv. Models of air-tight overhead tanks and sumps, highlighting the mosquito-proof arrangements such as the lid assembly and the sieved overflow pipe opening.
   - v. Models showing efficient drainage of water from terraces and water channels to avoid stagnations responsible for mosquito breeding.
   - vi. Personal protection methods such as mosquito nets and window screens.
   - vii. In addition, blood slides with P. vivax and P. falciparum parasites were shown under the compound microscope. Charts showing the life-cycle of a malaria parasite, the need for early detection and treatment of malaria cases and the importance of species-specific treatment of malaria were also displayed.
   - viii. A set of panels highlighting various aspects of malaria in the urban and rural settings were also exhibited.
   - ix. Handbills containing tips on self-action for the prevention and control of malaria were distributed.

Reference Text for the Training of Teachers

A book entitled "Elementary Malariology" has been published by the Goa Board of Secondary and Higher Secondary Board authored by Dr. Ashwani Kumar.

GUIDELINE THREE

COMMUNICATION FOR BEHAVIOUR CHANGE

[**Note:** These guidelines are to National / State / District programme managers who organise IEC activities. Different guidelines are more applicable to one level or the other. Each country programme will have to decide at what level the guideline will apply]

1.Carryout of formative survey which consists of the following
(a)Situational analysis (IEC)
(if already available may be used)
(b)Prepare directory/inventory of all available educational materials and collect them. This may be entrusted to one partner with appropriate experience and may obtain information from all the potential sources
(c) Identify and behavioural gaps

2. Set an action plan for IEC strategy(based on district level RBM strategy and based on assessment)
(a) Idenify possible target groups
(b) Define media/channel
(a) Scheduling

3. Develop IEC materials (as and when necessary)
(a)Design messages
Prepare a list of messages there are generic and applicable to all populations, that are scientifically accurate, acceptable to or approved by peers in malaria control, focussing on action points, structuring educational materials correctly, such as minimum lines per poster.

- Messages should be prepared for different groups.
- Messages should be classified sectors and distributed to the faculty of these disciplines to be incorporated into their curriculum.
- The messages relating to vectors should be area specific depending on whether it is forest; border; revenue; tribal; construction site; industrial; irrigation site; domestic – urban, overhead tanks, coolers, water pots; drinking water for animals; coconut shell; car tyres.

Messages should be region specific such as handling run off water from hand pumps, covers for manholes, etc. (Picture of hand pump). Simulation games may be developed for health workers and school children to highlight messages. There is a need for developing appropriate communication methods for the illiterate populations.

(b) Pretest

(c)Revise

(d)Produce IEC material. Explore local decentralised low cost production.

(e) Distribute, Disseminate and communicate the IEC materials and product as planned (Identify person/institution in-charge at all level)

The message dissemination will consist of

- Product/Service distribution such as printing and electronic media
- Using mass media such as local radio,television ,news paper and traditional media
- Face to face communication (individual and group) such as training, orientation seminars, workshop and field visits.

Communication

4. Communication strategy based on interactive participatory two-way approaches should be planned and some of the principles to be followed are:

   - This is to be a two way process.
   - Qualitative and participatory rural methods which facilitate two way communication are to be taught to health worker.
   - Communications skills also need to be taught to health personnel by some one who is committed and capable.
   - Catchy events and events from the life of important may be used for communication.
   - Communication should be simple, straightforward and direct.
   - Communications are encouraged to listen to what the community has to say before education.
   - Communication must be adapted to the four phases namely that of awareness, knowledge, attitude and practices.
   - Tools should be developed for each phase.
   - Role plays should be utilised for attitude change, emphasizing how people don't do certain things in a particular way.
   - Community should know where blood smear is carried out.
   - Teaching the skills of blood slide making is a high priority.
   - Instead of IEC, health education or behaviour modification strategies may be adopted, analysed in a socio political perspective
   - Communication should use the curricular approach with observable, measurable, feasible and relevant objectives. These should be provided after obtaining community feedback. It should be learner oriented rather than teacher oriented.
   - IEC materials are for self learning and group education.
   - The electronic media should preferably be used where need to update and revision is not needed.

Innovations

5. New and innovative methods of communication should be evolved and experimented with:
   - Colouring books / sheet on mosquitoes and malaria control.

- Develop educational toys around the theme of malaria.
- Activity modules for science experiments
- Audio visual material on the human stories about malaria, for example 'why did Mr Y die ?' reflecting a death due to malaria should be produced.

6. Monitoring evaluation and re-planning.

7. Information resource centres on malaria may be identified and developed with necessary infrastructure equipment and personnel keeping sustainability in mind right from the beginning. These may be from outside the government sector as well. Gradually, areas other than malaria may also be covered. These centres may review materials, determine suitability for local culture and guidance and promote materials to various groups.

8. Information materials could include:

- ✓ Posters
- ✓ Handbill
- ✓ Flash card
- ✓ Booklets
- ✓ Video cassettes
- ✓ Audio cassettes

Maintain quality of education with respect to choose language that is simple, unambiguous in mother tongue focusing on specific spoken dialect, with emphasis on marginalised and tribals.

9. The following methods of interactive education are to be utilised:

- ✓ Role play;
- ✓ Street theatre;
- ✓ Folk songs;
- ✓ Exhibitions;
- ✓ Puppet shows;
- ✓ Jathas

Folk artists should be treated as professional at their own level and should be reasonably remunerated.

10. IEC programmes should be evaluated. There should be both pre and post evaluation. It should consist of knowledge, attitudes and practices and processes.

BUILDING LEADERSHIP AT DISTRICT LEVEL

The malaria core group(coordination team)

The malaria programme activities at the district level needs the involvement of the following:

- The district administrator
- District Health Officer
- Health Officer designated for malaria, if available.
- Educational Officer
- Agricultural Officer
- Public Works engineer.
- Officers in charge of:
    - ❖ water /sewerage/
    - ❖ irrigation
    - ❖ rural/urban development
    - ❖ social welfare

Step One

A coordination committee chaired by the district administrator and health/malaria officer as secretary will be the first step to develop leadership at the district level. In keeping with the new philosophy of RBM, representatives of leaders of the community, NGOs, private practitioners and industry should also be included in the committee so that the ownership and the stakes of a much wider group is facilitated.

Step Two

The committee should evolve mechanisms for:

- ♦ Promoting participation
- ♦ Sharing information
- ♦ Formulating strategic action plans
- ♦ Implementation and its monitoring
- ♦ Reviewing partnership
- ♦ Fostering new partnerships, and
- ♦ Interdepartmental and intersectoral coordination

Step Three

Prepare advocacy materials applicable for the district to motivate participation by all these sectors.

Step Four

Communicate malaria control plans for the district to various partners involved in the programme.

Step Five
Facilitate the participation of the community as the central theme of the programme.

Step Six
Constantly review the malaria situation and programme with all partners, especially the community.

Develop Capacity

The success of RBM will rest on the capacity on district level officers placed in charge of the programme to carry out the above steps. For this purpose, they will need training /orientation to develop the following skills:

- Managerial and leadership
- Strategic planning
- Monitoring and evaluation
- Communication
- Networking and partnership
- Advocacy
- Community mobilisation
- Resource mobilisation
- Social marketing and
- Rapid appraisal procedures

Identify training centres and resource persons

Suitable resource persons and training centres from governmental and non-governmental sectors should be identified for this capacity building process.